

Complete Summary

G U I D E L I N E T I T L E

Domestic violence. A guide to screening and intervention.

B I B L I O G R A P H I C S O U R C E (S)

Brigham and Women's Hospital. Domestic violence. A guide to screening and intervention. Boston (MA): Brigham and Women's Hospital; 2004. 11 p. [23 references]

G U I D E L I N E S T A T U S

This is the current release of the guideline.

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SCOPE

D I S E A S E / C O N D I T I O N (S)

Domestic violence (domestic abuse)

G U I D E L I N E C A T E G O R Y

Counseling
Diagnosis
Evaluation
Management
Risk Assessment
Screening

C L I N I C A L S P E C I A L T Y

Emergency Medicine
Family Practice
Internal Medicine
Obstetrics and Gynecology

INTENDED USERS

Advanced Practice Nurses
Nurses
Physician Assistants
Physicians
Social Workers

GUIDELINE OBJECTIVE(S)

To provide recommendations on screening and interventions for women exposed to domestic violence

TARGET POPULATION

Women (including pregnant women) exposed to domestic violence or at risk

INTERVENTIONS AND PRACTICES CONSIDERED

Screening

1. Universal screening for domestic abuse
2. Documentation of screening

Clinical Evaluation

1. Patient history
2. Assessment of psychological symptoms
3. Physical examination
4. Assessment of behavioral indicators
5. Assessment during pregnancy and childbirth

Interventions

1. Acknowledgment and validation of the patient's disclosure
2. Response to the medical consequences of the abuse
3. Assessment of immediate or present threat
4. Development of a safety plan
5. Referral to hospital and community resources

Documentation

1. Documentation of domestic violence
2. Photographing injuries

MAJOR OUTCOMES CONSIDERED

- Incidence of domestic abuse, including physical, sexual, verbal, economic, and emotional abuse by men against their female partners
- Rate of participation in social work, domestic violence, and employee assistance programs

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Subjective Review

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

These guideline recommendations were reviewed by the Women's Health Guidelines Editorial Review Board.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Mandatory Reporting of Abuse

According to Massachusetts State Law, gunshot wounds and serious burns (>5 percent of body affected) should be reported to the Colonel of the State Police and the town police where the injury occurred. Burns should also be reported to the State Fire Marshall. Stabbings or injuries with sharp objects, if in the physician's opinion a criminal act was involved, also require reporting to the police in the town where the injury was treated.

There is no state mandate to report domestic violence. However, appropriate assessment and intervention by providers, is required. Sexual assault requires a report to the state police without identifying the victim. Abuse of children, elders, and disabled persons requires reporting to state protection agencies.

Screening for Abuse

Universal screening is the best way to identify abuse. As part of routine care, providers should screen all patients for abuse, whether signs, symptoms, or behaviors suggesting the presence of abuse are present or absent. Pregnant women should be screened at the initial visit and again in the third trimester. Simply asking about abuse is an intervention. Even if a patient does not disclose abuse, she will know that the provider is concerned and the hospital or clinic is a safe place to access assistance should she need it in the future. It is a matter of opening - and leaving - the door open.

Screen patients when they are alone, without anyone else present in the room. It is unsafe to screen in the presence of another person. Do not ask the patient for her consent to meet alone. Standard practice is to ask family and friends to wait in the waiting area during history taking or physical examination. If the provider is unable to meet with the patient alone or if a trained medical interpreter is unavailable, screening should be deferred with a note in the medical record stating this. Of note, a patient may be at risk for retaliation by an abusive partner if she discloses abuse to a health care provider.

Domestic Violence Screening Documentation

Document screening in the patient's medical record. If the person answers "No" to the screening questions, let her know that support is available related to abuse and patient safety should she ever need them.

Write: "Routine screening questions for abuse asked. Patient stated that abuse is not an issue at present time." Do not write: "Patient denies abuse."

Many abused persons who are afraid to talk about their situation at one time may return in the future and disclose abuse if they perceive that there is help available. If a provider writes that the patient "denies" abuse and the situation becomes a legal matter, the subjective documentation creates a legal doubt about whether or not the patient is a credible reporter.

Introductory Statement

The following introductory statements can be used to screen patients for abuse:

- Abuse against women has an impact on health and well-being and is very common. I ask all of my patients if anyone is scaring, threatening, or hurting them in any way.
- I'm so concerned about family violence that I ask every patient about this, just as I ask about other health issues.

Screening Questions

- Have you ever felt unsafe or been afraid of anyone (for example, your partner, a relative, or anyone else)?
- Is anyone trying to control you (for example, whom you see and talk to, where you go, what you wear, how you spend money)?
- Has anyone ever hurt or threatened to hurt you or someone else that you care about? For example, has anyone ever, hit, kicked, slapped, or punched you or forced you to perform sexual acts against your will?
- For pregnant patients: Since you've been pregnant, have you been hit, slapped, kicked, or otherwise physically hurt by someone?

Additional Questions/Statements for Patients in Whom a Provider Identifies High Index of Suspicion

- How does your partner get along with your family and friends?
- Most couples argue from time to time. When you and your partner argue, do you feel afraid?
- When your partner is angry, how does he/she act? Does he/she get physical and push, grab, or hit you? Does your partner force you to have sex or hurt you during sex?
- I'm worried; this doesn't look like you fell.

Response to Screening

A person is more likely to disclose abuse when she:

- Perceives that the provider is actively listening and concerned
- Understands the provider's reason for screening
- Feels assured that the disclosure will not be reported back to the abuser

Note: A negative response to screening does not mean that abuse is not present. It may indicate that the person is not comfortable disclosing abuse at this time.

Barriers to Disclosing Domestic Violence

Interpersonal Barriers

- Patient is afraid that provider will judge her.
- Abuser has threatened to harm the patient if she discloses abuse.
- Patient lacks confidence in the system.
- Patient fears no one will believe her, will blame her for staying with the abuser, or will blame her for not taking action sooner.
- Patient has never talked about the abuse and does not know how to bring it up.

Lack of Access to Information and Resources

- Patient is not aware that what she is experiencing is domestic abuse.
- Patient thinks that what she is experiencing is not serious enough to qualify as "domestic violence."
- Patient is unaware that resources are available to help her or she is unable to access resources because of abuser's control.
- Patient lacks financial or social independence.
- Patient is concerned about the safety and welfare of children.

Provider and Institutional Barriers

- Provider has not asked screening questions.
- Screening is not conducted in patient's native language.
- Patient is concerned about disclosing information about the abuser because abuser also receives care from the same provider or at the same institution.
- Patient is afraid that disclosure of abuse will result in notification to authorities, which may exacerbate the abuse at home.

Clinical Evaluation

History	<ul style="list-style-type: none"> • Chronic unexplained pain, including persistent headache, abdominal, pelvic, or chest pain • Chronic medical conditions such as chronic gastrointestinal (GI) complaints, irritable bowel syndrome, chronic back or joint pains, chronic fatigue, various somatic complaints • Sexually transmitted diseases and exposure to human immunodeficiency virus (HIV) through sexual coercion • Multiple therapeutic abortions
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	<ul style="list-style-type: none"> • Exacerbation of symptoms of a chronic disease such as diabetes or asthma • Intra-oral injuries, facial pain • Non-compliance with medical treatment, frequently missed appointments
Psychological Symptoms	<ul style="list-style-type: none"> • Insomnia, sleep disturbances • Depression and suicidal ideation • Anxiety symptoms and panic disorder • Eating disorders • Substance abuse, including tobacco • Post-traumatic stress disorder • Somatoform disorders • Use of psychiatric services by victim or partner
Physical Findings and Common Characteristics of Injuries Caused by Domestic Violence	<ul style="list-style-type: none"> • Any injury, especially to face, head, neck, throat, chest, abdomen, and genital areas • Poor dental hygiene • Dental or temporomandibular joint (TMJ) trauma • Burns • Signs of sexual assault • Central distribution of injuries, which can be covered up with clothing • Defensive injuries of the forearms • Wrist and ankle lacerations from being bound • Injuries that are not explained adequately or consistently • Injuries to multiple areas • Bruises of different shapes and sizes, reflecting types of weapons used • Bruises in various stages of healing
Behavioral Indicators	<ul style="list-style-type: none"> • Delay in seeking treatment • Repeated use of emergency services for trauma or primary care • Evasiveness during history taking or examination • References to partner's temper or anger • Reluctance to speak in partner's presence • Partner answers all questions for patient or insists on being present when asked to leave exam room • Overly attentive or verbally abusive partner • Abuse or neglect of children, disabled person, or elderly adult in the home • Abuse of pets
Findings During Pregnancy and Childbirth	<ul style="list-style-type: none"> • Frequently missed prenatal appointments, late or no prenatal care

	<ul style="list-style-type: none"> • Low maternal weight gain • Any injury including "falls" (1/3 of all trauma in pregnancy) • Complications such as miscarriage, low birth weight infant, premature labor, premature rupture of membranes, and antepartum hemorrhage • Poor self-care or compliance • Substance abuse, including tobacco or alcohol during pregnancy
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Intervention

Step 1. Acknowledge and Validate the Patient's Disclosure

An abused person experiences isolation and shame. The provider's first step in responding to a disclosure of abuse should be to validate the person's experience and concerns.

Validating and Supportive Statements	Harmful Statements
<ul style="list-style-type: none"> • You are not alone. • You deserve to be safe. • I'm so sorry that this is happening to you. • I'm glad you told me—I'd like to help. • I'm concerned for your safety. • There are resources available here for you. • The abuse is not your fault. • You don't have to deal with this alone. • I can offer you some helpful information and contacts. 	<ul style="list-style-type: none"> • Are you a victim of domestic violence? • What was your part in the argument or fight? • Why did you get involved with him if you were aware of his violence? • Why didn't you tell me sooner? • Why didn't you just leave him the first time he hit you? • Why didn't you call the police? • Why didn't you get a restraining order? • Why do you stay?

It is important for providers to examine their own assumptions and biases with regard to gender, race, culture, age, and sexual orientation when speaking with abused patients. Providers' personal biases may affect their ability to initiate interventions.

Step 2. Respond to the Medical Consequences of the Abuse

- Assess effects of abuse on patient physically and mentally.
- Examine current and past injuries.
- Treat injuries and other medical complaints as indicated.

Step 3. Assess Immediate or Present Threat

- Ask if the patient is afraid that the abuser will harm her today.
- Determine if the abuser is present in the hospital or medical office, and whether the abuser is aware that the patient is seeking medical care or support services.
- Obtain information about the abuser: name of the abuser, prior incidents of abuse, drug use, types of weapons used, and types of weapons in the home.
- Ask about the abuser's threats. Has the abuser threatened to harm or kill the patient?
- Does she feel safe in the office today? Does she feel safe enough to go home?
- Is the patient concerned that her children or loved ones are in immediate danger?

If there is an immediate or present threat, follow security procedures.

Step 4. Develop a Safety Plan

- Ask if the patient has a plan if the violence or abuse escalates. Review the safety plan.
- Ask about patient's ability to access supports and services.
- Always refer the patient to a social worker and/or domestic violence program to assist the patient in developing a safety plan.

Step 5. Utilize Hospital and Community Resources

- Contact a social worker for questions about intervention or documentation, and for consultation.
- Many health care institutions have domestic violence programs and/or advocates. Be aware of the contact information for these programs in your area.

Step 6. Document Findings in Medical Record

- For detailed recommendations on documentation of domestic abuse, see below.

Documenting Domestic Violence

Medical records are often the best and only documentation of abuse that can be used in court. Providers who document detailed, objective, and legible accounts of patient presentations are less likely to be subpoenaed to appear in court than are those who write vague, subjective, and illegible notes about abuse. Words and phrases that are commonly used in medical records may have a very different meaning in court. In some cases, such phrases may be misinterpreted as disbelief on the part of the provider.

Documentation should provide detailed and objective information and include the following:

- Date and time of incident or abusive situation

- Patient's account of what happened, including the first and last name of the person who abused her. Include specific details about the incident, including type and nature of threats, injuries sustained, and weapons used.
- History of previous incidents of abuse with the abuser (physical, sexual, emotional, verbal, economic, etc.)
- Description of physical findings
- Provider's assessment, recommendations, information provided, safety planning, resources, and referrals provided to patient
- Documentation of mandatory reporting of child, disabled, or elder abuse

If clinicians make an assessment that is in conflict with the patient's report of the situation, note the difference. For example: "Although the patient, who is six months pregnant, reports that she accidentally fell down the two flights of stairs, provider questions if injury was inflicted. Patient previously has reported multiple incidents of physical abuse by boyfriend. She said that he often hit her and shoved her during her past pregnancy in 1998. When speaking today about the fall, patient did not make eye contact, declined to answer, and began to cry when I asked if her boyfriend pushed her down the steps."

Documentation Tips

<ul style="list-style-type: none"> • Write "screening for abuse is negative at the present time." 	<ul style="list-style-type: none"> • Avoid writing "patient denies abuse."
<ul style="list-style-type: none"> • Record the patient's spontaneous statements in quotation marks. Such statements, legally termed "excited utterances" are admissible in court. 	<ul style="list-style-type: none"> • Do not tell the patient that the statements she is about to make may be used in court. The statements then no longer qualify as spontaneous, excited utterances and will be disqualified.
<ul style="list-style-type: none"> • Write "patient stated" or "patient reports" (e.g., "patient reports that her boyfriend, Joe Smith, twisted her arm behind her back"). 	<ul style="list-style-type: none"> • Avoid writing "patient alleges" or "patient claims."
<ul style="list-style-type: none"> • Record what you saw and heard and write "Patient was shaking and crying while describing the incident where her husband threatened to kill her." 	<ul style="list-style-type: none"> • Avoid phrases that leave room for misinterpretation. For instance, avoid writing "Patient was hysterical."
<ul style="list-style-type: none"> • Describe what you see on exam, including various locations, shapes, and sizes of bruises, as well as colors. A body map is most useful. 	<ul style="list-style-type: none"> • Do not attempt to "date" bruises subjectively, as this can lead to contradiction and doubt in court.

Photographing Injuries

Photographic documentation is intended to complement written documentation and provides additional evidence of abuse that can be used in court proceedings. Take photographs only if a patient consents verbally and signs a written consent form specifically authorizing photography. Place photographs in a sealed envelope within a medical record and label as "Confidential - to be used only for litigation purposes."

All patients should be offered the opportunity to have photographs taken. If a patient agrees, complete the written consent form. The photographer must follow the following guidelines for photographs to be useful:

1. Take an initial photo of the person, including the person's face and any visible injuries. It is helpful to include an identifying document (e.g., person's license or ID) in the set of photos.
2. Take a medium range photo showing the location of the injury on the person's body.
3. Take close-up photos of the injury or injuries. Be sure to include a photo that enables the viewer to identify the body part where the injury was sustained.
4. Label each photo with the date (including year) and time the photo is taken, the name of the hospital, the name of the patient, the signatures of the patient, the photographer, and a witness.

CLINICAL ALGORITHM(S)

A clinical algorithm is provided in the original guideline document for "Domestic Violence Screening."

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of evidence supporting the recommendations is not specifically stated.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate assessment and management of women exposed to domestic violence

POTENTIAL HARMS

A patient may be at risk for retaliation by an abusive partner if she discloses abuse to a health care provider.

CONTRAINDICATIONS

CONTRAINDICATIONS

Contraindicated Interventions

- Couples, marital, or family therapy
- Anger management groups (or any non-certified batterer group) that do not provide safety planning for the victim
- Mediation for legal issues, divorce, and custody
- Confronting the abuser or suggesting that the victim confront the abuser
- Any intervention without a safety plan or without the victim's consent

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

This guideline is not intended to convey rigid standards, but instead should be tailored to the needs of the individual woman

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

IMPLEMENTATION TOOLS

Clinical Algorithm

For information about [availability](#), see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Brigham and Women's Hospital. Domestic violence. A guide to screening and intervention. Boston (MA): Brigham and Women's Hospital; 2004. 11 p. [23 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2004

GUIDELINE DEVELOPER(S)

Brigham and Women's Hospital (Boston) - Hospital/Medical Center

SOURCE(S) OF FUNDING

Brigham and Women's Hospital

GUIDELINE COMMITTEE

Not stated

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the [Brigham and Women's Hospital Web site](#).

Print copies: Available from the Brigham and Women's Hospital, 75 Francis Street, Boston, Massachusetts 02115. Telephone: (800) BWH-9999.

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

None available

NGC STATUS

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